U.S. Department of Labor

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Issue Date: 23 January 2006

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In the Matter of:

HARRISON CREAR,
Claimant,

v. **Case No.: 2004-BLA-06155**

DRUMMOND COMPANY, INC.,
Employer, and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

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Appearances:

Roderick Graham, Esq., Birmingham, AL
For Claimant

C. Andrew Kitchen, Esq., Maynard, Cooper & Gale, P.C., Birmingham, AL
For Employer/Carrier

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a duplicate or subsequent claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter "the Act"). The claim concerned here was filed by Claimant Harrison Crear ("Claimant") on May 7, 2003. The putative responsible operator is Drummond Company, Inc. ("Employer"). No payments are being made by the Black Lung Disability Trust Fund.

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980, and the regulations amended as of December 20, 2000 are also applicable, as this claim was filed after January 19, 2001. 20 C.F.R. § 718.2. In *National Mining Assn. v. Dept. of Labor*, 292 F.3d. 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected a challenge to, and upheld, the amended regulations with the exception of several sections which were found to be impermissibly retroactive and one which attempted to

effect an unauthorized cost shifting. The Department of Labor amended the regulations on December 15, 2003, solely for the purpose of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all evidence admitted and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

The instant claim is the second one filed by the Claimant.

Claimant's first claim for Black Lung benefits was filed on January 5, 1999. (DX 1).[1] Claimant advised that he was born in September 1942 and had stopped working in the coal mines on May 11, 1997 after 22 years of such employment.[2] *Id.* Following an examination conducted by Dr. Jack Hassan on February 24, 1999, the claim was denied by a Claims Examiner on May 11, 1999, because the evidence did not show that Claimant had pneumoconiosis, that it was caused at least in part by coal mine employment, or that he was totally disabled by the disease. *Id.* No appeal was filed and that decision became final.

The instant claim was dated March 11, 2003 and was filed on May 7, 2003. (DX 3). A medical examination was conducted by Dr. Zakir Kahn on June 5, 2003. (DX 14). On August 21, 2003, the district director's office issued a "Schedule for the Submission of Additional Evidence" which indicated that they had made the following preliminary conclusions:

1. The claimant would be entitled to benefits if we issued a decision at this time; and
2. The coal mine operator named above ["Drummond Company Inc"] is the responsible operator liable for the payment of benefits.

(DX 19). However, after consideration of additional evidence, the District Director issued a Proposed Decision and Order Denial of Benefits on March 25, 2004, which denied benefits because the evidence did not show that the Claimant had pneumoconiosis, that it was caused at least in part by coal mine work, or that the disease caused a breathing impairment of sufficient degree to establish total disability within the meaning of the Act and the regulations (DX 26). Claimant, through counsel, appealed and the case was referred for a hearing on April 22, 2004. (DX 28, 29).

A hearing was held before the undersigned administrative law judge on December 14, 2004. Employer submitted a Prehearing Report at the hearing that summarized the evidence and, prior to the hearing, designated the evidence relied upon by the Employer. At the hearing,

[1] References to exhibits admitted into evidence at the December 14, 2004 hearing appear as "DX" for Director's Exhibits, "CX" for Claimant's Exhibits and "ALJ" for Administrative Law Judge Exhibits, followed by the exhibit number. Claimant's prior claim appears at "DX 1." References to the hearing transcript appear as "Tr." followed by the page number.

[2] Records from Drummond Company, Inc. verified that he was employed by them from February 4, 1975 until January 1, 1998, when he retired, although the last work listed was as "Motorman" from June 23, 1987 until May 12, 1997, when he was laid off. (DX 6).

Director's Exhibits 1 through 29, Claimant's Exhibit 1 (a report by Dr. Ernest Claybon) and Administrative Law Judge Exhibit 1 (a supplemental medical opinion by Dr. Kahn submitted by the Director under cover letter of December 6, 2004)[3] were admitted into evidence. Claimant was the only witness to testify. The record closed at the end of the hearing but the parties were given until March 1, 2005 to submit any briefs or written closing arguments, which period could be extended for an additional 30 days by stipulation. Employer's written closing argument, dated February 28, 2005, was filed on March 1, 2005 and Claimant's written closing argument, served on the parties on February 28, 2005, was filed on March 11, 2005. Both briefs are accepted as timely. The case is ready for decision.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Issues/Stipulations

Although "Modification" was listed as an issue on the Form CM-1025 transmittal (DX 29), the parties agreed that it was not at issue and it appears to have been listed in error and is **STRICKEN**. (Tr. 7-8). **SO ORDERED**.

There were no formal stipulations. However, length of coal mine employment was not listed as an issue, and the parties do not dispute that Claimant had at least the 22 years and 11 months of coal mine employment found by the Director. (DX 29). It is also undisputed that the Claimant has two dependents for augmentation purposes. *Id.*

Accordingly, the issues for resolution by this tribunal are:

1. Whether Claimant has pneumoconiosis as defined by the Act and the regulations;

2. Whether Claimant's pneumoconiosis arose out of coal mine employment;

3. Whether Claimant is totally disabled;

4. Whether Claimant's disability is due to pneumoconiosis;

5. Whether the evidence establishes a material change in conditions since the last prior denial under 20 C.F.R. §725.309(c), (d) (Subsequent Claim).[4]

(DX 29).

Because the instant case involves the second claim filed by the Claimant, and the previous denial was final, there is a threshold issue – whether there is a basis for reopening the claim under 20 C.F.R. §725.309, as amended.

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[3] ALJ 1 was admitted over Employer's objection, which was based upon the assertion that the Employer had not had an opportunity to review the report or have one of its physicians review it. (Tr. 6-7, 40). Employer did not renew the objection in its brief.

[4] As amended in December 2000, the regulations do not include the "material change in conditions" criteria. The pertinent criteria under amended section 725.309 are discussed below.

Evidence

Claimant's Hearing Testimony

Claimant was a credible witness. He indicated that he was a resident of Birmingham, Alabama, having lived there for 33 years. (Tr. 8).

Claimant testified that he first started working in the mines on February 4, 1975, working first as a trainee for "underground general" work. (Tr. 9). In that capacity, he shoveled the belt line to keep it clean and did different odd jobs. *Id.* For the first 90 days, he was not allowed to go to the face of the mine, where the coal was cut. *Id.* However, the area where he worked was dusty, because the belt and the coal being carried put off dust, and it was hazardous, because he had to walk over rocks and other stuff. (Tr. 9-10).

Claimant's next job was as timber helper, which involved a little bit of everything, including hanging curtain or running a scoop for a shuttle car. (Tr. 10-11). That job was very dusty, and he worked at the face of the mine. (Tr. 11, 12). He continued with that work until September or October of 1975, when he bid on a scoop job, a job which he held for three years. (Tr. 11, 15).

The scoop job involved bringing a cutting machine from the shack to the face and scooping out the rock dust, leftover coal, and whatever else was left behind, then returning it to the shack for the guard or motorman to pick up. (Tr. 12-13). At that job, he was in dust 98 or 99 percent of the time. (Tr. 13). The rock dust was used to keep down explosions from gas in the mine, and they would have to cut a sack of rock dust open and sweep it on the top and around the rim. (Tr. 13-14). They were given masks, but he frequently was unable to wear them because they were so uncomfortable. (Tr. 14). The sacks contained warnings that it was hazardous to breathe the contents, and there were also safety meetings. (Tr. 14-15).

After his three years as a scoop operator, he bid on a trip rider job. (Tr. 15). As a trip rider, he helped the motorman chain, couple cars, uncouple cars, throw switches, flip brakes on, jack the cars, carry material to the tail piece, and unload everything they used close to the face, such as pins, bolts, and cutting oil. (Tr. 15-16). They also removed waste (such as empty cans, rock dust sacks, old curtain packs, and unusable water hoses) from the mine. (Tr. 16). The trip rider job was hazardous and involved a lot of lifting and hard work, as well as considerable dust, especially in the wintertime. *Id.* Visibility was restricted due to the dust and overall he was exposed to more dust than when he was a timber helper, because he was constantly going by dusty areas on the track, such as headers and tail pieces. (Tr. 17). He worked as at trip rider for a full nine to ten years. (Tr. 18).

At the safety meetings, they told him to try not to inhale more than he needed to, and they acknowledged that it was impractical to wear a respirator all the time. (Tr. 17). He was also advised about the dangers of coal dust and gas and told how to give artificial respiration, and they demonstrated how dangerous an explosion was. *Id.* He was told that the dust on the track was more dangerous than that on the face, because the dust on the face was not as fine. (Tr. 18).

Claimant was promoted to motorman in 1987 and he continued in that capacity until May 11, 1997, when he was laid off. (Tr. 18-19). That job involved operating a motor vehicle and also doing the same things that he did as a trip rider. (Tr. 18-19). He was still in the same hazardous environment. (Tr. 19). After Claimant was laid off, he never went back to work, because the mine closed down. *Id.* Although the records say that he retired on January 1, 1998, he did not work from May 12, 1997 to January 1, 1998. (Tr. 33).

All of Claimant's coal mine employment, from 1975 to 1997, was at the same mine -- Mary Lee Number 1. (Tr. 20).

Claimant testified that he never smoked cigarettes or used any kind of tobacco products. (Tr. 20).

Claimant first experienced breathing problems in the late 1990's, when he started getting short of breath and it was more complicated for him to breathe. (Tr. 20-21). He was still working in the mines at that time, and on cross examination he admitted that it did not prevent him from working. (Tr. 21, 37). In addition to shortness of breath and difficulty breathing, he coughed a lot. (Tr. 21) He told the doctors about it, complaining to them on a regular basis, but they never treated him. *Id.* On cross examination, he said that he mainly visited Dr. Claybon [mistranscribed as Clayborn] and Dr. Lattin for colds, which he was having frequently, but that he was having breathing problems and they may have treated him for that too. (Tr. 32-33). Dr. Claybon never told him that he had pneumoconiosis that he can recall. (Tr. 33). He does not recall Dr. Claybon diagnosing him with COPD in April 1997 but he could have. (Tr. 39).

Claimant has not consciously experienced heart problems, although he was diagnosed with irregular heartbeat in the 1990's. (Tr. 21-22). Dr. Claybon was his physician at the time. (Tr. 22). He never found out what caused it or received any treatment, as far as he knows. *Id.* In addition, in April 2004 he was sick and went to the hospital because his heart was weak. (Tr. 22-23). Claimant first saw Dr. Claybon in the 1970's and Dr. Claybon has treated him since. (Tr. 26, 29). He has also been seeing Dr. Lattin (but not for breathing problems) since the early 1990's. (Tr. 26-27). Dr. Dailey also set him up for a heart catheter but found no blockage. (Tr. 27-28). No one has told him that he has an enlarged heart. (Tr. 31).

Some time around 1993, Claimant first had trouble breathing, especially when he slept or lay down, and a lot of times he gasped for air and had to jump up quick. (Tr. 23). He did most of his sleeping sitting up so that he could take deep, long breaths in order to get the air that he needed. *Id.* The condition keep on getting worse and worse, each year, to the point at which he could only walk about 50 feet. (Tr. 23-24). It has kept him from doing any kind of work. *Id.*

Claimant has other medical problems, including insulin dependent diabetes and obesity. (Tr. 24). He has never been told that the diabetes was uncontrolled and he denied that the diabetes was ever disabling. (Tr. 32, 36). When he worked in the mines, in the late 1980's, he weighed between 250 and 265; however, he was only 230 when he started working there. (Tr. 25). At the present time, Claimant weighs 278 pounds. (Tr. 25). Claimant did not dispute that he weighed 280 pounds when he visited Dr. Claybon's office on January 12, 1996. (Tr. 29-30). At that time, he was still working in the mines. (Tr. 30). No one has told him that his shortness

of breath was attributable to obesity although "they said it could." *Id.* His attempts to lose weight have been unsuccessful. *Id.*

On cross examination, Claimant discussed other health problems. He admitted to having sustained a gunshot wound to his torso in 1978. (Tr. 31). He does not know of any ill effects from the gunshot wound. *Id.* He was out of work for "30-some days" due to that injury. (Tr. 38). He was not short of breath at that time. (Tr. 38-39). He also stated that he had been told that he has high blood pressure, but recently it has been under control. (Tr. 32). When asked whether he complained of right side pain, severe back pain, and disabling leg problems when he visited Dr. Claybon in the summer of 1997, he recalled the complaints but thought it was Dr. Lattin in 1998 and does not recall any severe pain in 1997. (Tr. 34-36). He had back problems in 1994. (Tr. 36). He also had kidney stones but does not recall they were the cause of his right side pain. *Id.* Kidney problems he experienced in the early 1970's resolved until they recurred in the 1990's. (Tr. 36-37). A stone broke up in 1993 or 1994. *Id.*

Medical Evidence

From the Claimant's previous claim, there was a medical examination report by Dr. Jack Hassan with associated testing (including electrocardiogram, an x-ray interpretation by Dr. Hassan with a quality interpretation by Dr. E. Nicholas Sargent, pulmonary function studies [pre bronchodilator only] found to be unacceptable by Dr. J. Michos, and arterial blood gases [resting only])[5] based upon a February 24, 1999 examination (DX 1); these records were resubmitted by the Employer (DX 20).

The new medical evidence submitted in connection with the instant claim consists of the following:

(1) the medical examination report by Dr. Zakir Kahn relating to the June 5, 2003 Department of Labor examination and associated test results (including electrocardiogram, an x-ray interpretation by Dr. P.H. Nath with a quality interpretation by Dr. Peter J. Barrett, pulmonary function studies [pre and post bronchodilator] validated by Dr. J. Michos, and arterial blood gases [resting and exercise]) (DX 14) and a supplemental report by Dr. Kahn (ALJ 1) (Director's Initial Evidence);

(2) a November 3, 2003 examination report by Dr. Allan R. Goldstein relating to an examination of the Claimant conducted on the same date, including an electrocardiogram, an x-ray interpretation by Dr. Goldstein, pulmonary function studies [pre and post bronchodilator], and resting arterial blood gases[6] (DX 23) (Employer's Initial);

(3) a December 29, 2003 review report by Dr. A. David Russakoff (DX 24) (Employer's Initial); and

[5] At the time of the February 24, 1999 examination, exercise ABGs were deemed to be contraindicated due to the Claimant's high blood pressure and multiple health problems. (DX 1, 20).

[6] Dr. Goldstein commented that exercise values were not taken due to the Claimant's clinical findings and chest pain. (DX 23).

(4) a medical report dated October 7, 2004 by Dr. Ernest A. Claybon, Claimant's treating physician, and associated medical records from 1996 to 1998 (CX 5) (Claimant's Initial).

DISCUSSION AND ANALYSIS

Evidentiary Limitations

My consideration of the medical evidence is limited under the regulations, which apply evidentiary limitations to all claims filed after January 19, 2001. 20 C.F.R. §725.414. Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. *Dempsey v. Sewell Coal Co.*, 21 BLR --, BRB No. 03-0615 BLA (June 28, 2004) (en banc) (slip op. at 3), *citing* 20 C.F.R. §§725.414; 725.456(b)(1). Under section 725.414, the claimant and the responsible operator may each "submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports." *Id., citing* 20 C.F.R. §725.414(a)(2)(i),(a)(3)(i). In rebuttal of the case presented by the opposing party, each party may submit "no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by" the opposing party "and by the Director pursuant to §725.406." *Id., citing* 20 C.F.R. §725.414(a)(2)(ii), (a)(3)(ii). Following rebuttal, each party may submit "an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing," and, where a medical report is undermined by rebuttal evidence, "an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." *Id.* "Notwithstanding the limitations" of section 725.414(a)(2),(a)(3), "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence." *Id., citing* 20 C.F.R. §725.414(a)(4). Medical evidence that exceeds the limitations of Section 725.414 "shall not be admitted into the hearing record in the absence of good cause." *Id.*, *citing* 20 C.F.R. §725.456(b)(1). The parties cannot waive the evidentiary limitations, which are mandatory and therefore not subject to waiver. *Phillips v. Westmoreland Coal Co.*, 2002-BLA-05289, BRB No. 04-0379 BLA (BRB Jan. 27, 2005) (unpub.) (slip op. at 6).

Evidence from prior federal black lung claims is automatically admissible under 20 C.F.R. §725.309(d)(1).

The Benefits Review Board discussed the operation of these limitations in its en banc decision in *Dempsey, supra*. First, the Board found that it was error to exclude CT scan evidence because it was not covered by the evidentiary limitations and instead could be considered "other medical evidence." *Dempsey* at 5; *see* 20 C.F.R. § 718.107(a) (allowing consideration of medical evidence not specifically addressed by the regulations). Further, the Board found that it was error to exclude pulmonary function tests and arterial blood gases derived from a claimant's medical records simply because they had been proffered for the purpose of exceeding the evidentiary limitations. *Dempsey* at 5. However, the Board found that records from a state claim were properly excluded as they did not fall within the exception for hospitalization or treatment

records or the exception for prior federal black lung claim evidence (under 20 C.F.R. §725.309(d)(1)). *Dempsey* at 6. On the issue of good cause for waiver of the regulations, the Board noted that a finding of relevancy would not constitute good cause and therefore records in excess of the limitations offered on that basis, and on the basis that the excluded evidence would be "helpful and necessary" for the reviewing physicians to make an accurate diagnosis, were properly excluded. *Id.* at 6. Finally, the Board stated that inasmuch as the regulations do not specify what is to be done with a medical report that references inadmissible evidence, it was not an abuse of discretion to decline to consider an opinion that was "inextricably intertwined" with excluded evidence. *Id.* at 9. Referencing *Peabody Coal Co. v. Durbin*, 165 F.3d 1126, 21 BLR 2-538 (7th Cir. 1999), the Board acknowledged that it was adopting a rule contrary to the common law rule allowing inadmissible evidence to be considered by a medical expert, because "[t]he revised regulations limit the scope of expert testimony to admissible evidence." *Dempsey* at 9-11.

In this case, the record is in compliance with the evidentiary limitations.

Subsequent Claims Analysis

As this is the second claim filed by the Claimant, the instant claim is a duplicate or subsequent claim. Previously, such a claim would be denied based upon the prior denial unless the claimant could establish a material change in conditions. *See* 20 C.F.R. §725.309(d). Under the decision of the Benefits Review Board in *Allen v. Mead Corp.*, 22 B.L.R. 1-61 (2000), to establish a material change in conditions under §725.309, a claimant must establish, by a preponderance of the evidence developed subsequent to the denial of the prior claim, at least one of the elements of entitlement previously adjudicated against him. *See also Caudill v. Arch of Kentucky, Inc.*, 22 B.L.R. 1-97 (2000) (en banc on recon.) However, evidence in existence at the time the first claim was decided may not establish a material change. *See Cline v. Westmoreland Coal Co.*, 21 B.L.R. 1-69 (1997)

The amended regulations have replaced the material-change-in-conditions standard with the following, essentially similar standard:

> (d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see §725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. **A subsequent claim** shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim **shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement** (see §§725.202(d) (miner), 725.212 (spouse), 725.218 (child), and 725.222 (parent, brother, or sister)) **has changed since the date upon which the order denying the prior claim became final.**[7] The applicability of this paragraph may be waived by the operator or fund, as

[7] For a miner, the conditions of entitlement include whether the individual (1) is a miner as defined in the section; (2) has met the requirements for entitlement to benefits by establishing pneumoconiosis, its causal relationship to coal mine employment, total disability, and contribution by the pneumoconiosis to the total disability; and (3) has filed a claim for benefits in accordance with this part. 20 C.F.R. §725.202(d) *Conditions of entitlement: miner.*

appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
(1) Any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
(2) For purposes of this section, **the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based.** For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
(3) **If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement.** . .
(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim. . . .[Emphasis added.]

20 C.F.R. § 725.309(d) (2003).

The previous claim was denied because the Claimant failed to establish any of the medical elements of entitlement. Thus, in order to satisfy the regulatory criteria, the Claimant must establish either that he suffers from pneumoconiosis, that the disease was caused at least in part by coal mine employment, that he is totally disabled, or that the total disability was due to pneumoconiosis, based upon the newly submitted evidence.

Without belaboring the issue, it appears that the Claimant may establish total disability based upon the recent pulmonary function studies, which are qualifying under the regulatory criteria, and the recent medical opinions, the consensus of which is that he is totally disabled. Thus, it is likely that the Claimant will be able to satisfy the requirements of section 725.309 and I will proceed directly to consideration of the merits of the claim. Specifically, I will now consider the evidence on the issue of pneumoconiosis, based upon first, the newly submitted evidence and then, all of the evidence of record.

Existence of Pneumoconiosis

In reviewing the evidence on the issue of pneumoconiosis, I must take into consideration the fact that it is the Claimant's burden of proof on that issue as with all others. In this regard, the Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. In *Director, OWCP v.*

Greenwich Collieries, 512 U.S. 267, 28 BRBS 43 (CRT) (1994), the Supreme Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants.

"Pneumoconiosis," commonly known as "black lung disease," is defined as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. §718.201(a) (2002). The definition has been modified to expressly include "both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal' pneumoconiosis." *Id.* The regulations define legal pneumoconiosis as "any chronic lung disease or impairment and its sequelae arising out of coal mine employment" and explain that "[t]his definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." 20 C.F.R. §718.201(a)(2) (2002). The section continues by stating that "'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* at §718.201(b). Thus, a claimant miner who cannot prove clinical pneumoconiosis may prove the existence of legal pneumoconiosis if he or she can show that his or her lung condition was substantially aggravated by coal mine employment.

The regulations (in section 718.202(a)) provide several means of establishing the existence of pneumoconiosis: (1) a chest x-ray meeting criteria set forth in 20 C.F.R. §718.102, and in the event of conflicting x-ray reports, consideration is to be given to the radiological qualifications of the persons interpreting the x-rays; (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. §718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" set forth in 20 C.F.R. §718.304 and two additional presumptions set forth in §718.305 and §718.306; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon objective medical evidence and supported by a reasoned medical opinion. 20 C.F.R. §718.202(a)(1) - (4) (2002). At least one United States Court of Appeals (the Fourth Circuit) has held that all of the evidence from section 718.202 should be weighed together in determining whether a miner suffers from pneumoconiosis. *See, e.g., Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-209 (4th Cir. 2000). *But see Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc) (noting "the Sixth Circuit has often approved the independent application of the subsections of Section 718.202(a) to determine whether claimant has established the existence of pneumoconiosis.") Finally, under section 718.107, other medical evidence, and specifically the results of medically acceptable tests or procedures which tend to demonstrate the presence or absence of pneumoconiosis, may be submitted and considered.

X-ray Evidence. Claimant has not proven the existence of pneumoconiosis by a preponderance of the new x-ray evidence as **none** of the newly submitted evidence is positive for pneumoconiosis. X-rays taken in connection with the instant claim on June 5, 2003 and on November 3, 2003 were uniformly interpreted as negative for pneumoconiosis. The June 5, 2003 x-ray was found to be negative for pneumoconiosis by dually qualified B-reader and board certified radiologist P.H. Nath, M.D., and the only abnormality noted by Dr. Nath was "co" (relating to an enlarged heart). (DX 14). Similarly, the November 3, 2003 x-ray was read by B-reader and board-certified pulmonologist Allan R. Goldstein, M.D., as negative for pneumoconiosis, and the only abnormality noted by Dr. Goldstein was "co" (relating to an

enlarged heart). (DX 23). Thus, the x-ray evidence developed in connection with the instant claim is uniformly negative for clinical pneumoconiosis.

Furthermore, when the x-ray evidence from the previous claim (that was resubmitted in connection with the instant claim) is considered, the outcome does not change. The only x-ray interpretations of record relating to the February 24, 1999 x-ray, by dually qualified reader Dr. Sargent and by B-reader Dr. Jack Hasson, were negative for pneumoconiosis, although Dr. Hasson noted an elevated hemidiaphragm and mediastinal fullness (rule/out mass) and Dr. Sargent made similar findings. (DX 1, DX 20). These abnormalities were not, however, noted on readings of the more recent x-rays.

Thus, Claimant cannot establish pneumoconiosis based upon the new x-ray evidence under section 718.202(a)(1), nor can he do so based upon all the x-ray evidence of record.

Biopsy Evidence. Claimant has failed to establish the presence of the disease under 20 C.F.R. §718.202(a)(2) as there is no biopsy evidence of record.

Complicated Pneumoconiosis and Other Presumptions. A finding of "complicated pneumoconiosis" under 20 C.F.R. §718.304 results in an irrebuttable presumption of total disability. There is no evidence of complicated pneumoconiosis or of opacities that would satisfy the definition of complicated pneumoconiosis. The additional presumptions mentioned in section 718.202(a)(3), which are set forth in 20 C.F.R. §718.305 and 20 C.F.R. §718.306, are also inapplicable, inter alia, because they do not apply to claims filed after January 1, 1982 or June 30, 1982, respectively, and section 718.306 only applies to death claims.

Medical Opinions on Pneumoconiosis. Claimant has also failed to establish the existence of the disease under 20 C.F.R. §718.202(a)(4) based upon the preponderance of the reasoned medical opinion evidence. The following medical opinion evidence has been submitted in connection with the instant claim:

(1) **Zakir Kahn, M.D.**,[8] from the Alabama Health Center, examined the Claimant for the Department of Labor on June 5, 2003. Dr. Kahn recorded a height of 69½ inches and a weight of 288 pounds. He noted that the thorax and lungs were normal on inspection, palpation, percussion, and ausculation and that the ABGs were normal. The electrocardiogram was interpreted as abnormal, and Dr. Kahn noted irregular sinus tachycardia and premature ventricular contractions. Dr. Kahn interpreted the pulmonary function tests as showing mild obstructive lung disease and impaired membrane diffusion.[9] He found that the Claimant had COPD (chronic obstructive pulmonary disease) based upon the pulmonary function testing and history, and hypertension, based upon history. He opined that the first condition (COPD) was due to coal dust inhalation but for the second condition (hypertension), he stated that the essential etiology was unknown. (DX 14). He concluded that the Claimant "would have

[8] Dr. Kahn's curriculum vitae is not of record.

[9] Interpreting the same PFTs, Dr. Russakoff stated that Dr. Kahn had misinterpreted them in that they showed a restrictive defect. (DX 24). A review of the test report itself reflects that Dr. Kahn had initially noted both restriction and obstruction but he crossed out the reference to a restrictive defect. (DX 14).

moderate difficulty performing his last coal mining job of one years duration" and found that the disability was to a significant extent due to COPD. *Id.*

In a supplemental report, filed with the district director on December 2, 2004, he summarized examination findings and stated:

> It is my opinion based on all the data listed previously including my examination and treatment that Mr. Crear suffers from pneumoconiosis. I define pneumoconiosis as any chronic respiratory or pulmonary condition due in whole or part to dust exposure in coal mine employment. The types of dust I consider are coal dust, rock dust and asbestosis dust.
>
> Mr. Crear has moderate to severe obstructive lung disease as well as coal worker's pneumoconiosis. His chronic respiratory conditions [sic] that is directly due to his occupational exposure to coal and rock dust is likely to be exacerbated by this exposure. Mr. Crear does not have the respiratory capacity to withstand the physical demands of his last coal mining job.

(ALJ 1).

(2) **Allan R. Goldstein, M.D.,** a board-certified pulmonologist,[10] examined the Claimant on November 3, 2003. In a report of the same date, he summarized the Claimant's history of coal mining for 23 years and symptomatology including shortness of breath of 12 years duration. He noted that the Claimant's symptoms were consistent with PND [paroxysmal nocturnal dyspnea], orthopnea, ankle edema, and possibly angina, and he stated that the Claimant's chest x-ray was "consistent with congestive heart failure and cardiomegaly as well as a widened mediastinum." On examination, he recorded a height of 70 inches and weight of 282 pounds, and he noted decreased breath sounds and a few rales. He found the pulmonary function test results to be consistent with a restrictive defect and he noted that the diffusion capacity was reduced but corrected for by alveolar volume. He explained:

> . . . His pulmonary functions are consistent with a restrictive defect that could be explained by his body stature and his cardiac condition. If it were to be explained by coal workers' pneumoconiosis one would expect to find abnormalities on the chest x-ray consistent with coal workers' pneumoconiosis and I see none.
>
> It is my impression that this gentlemen has significant shortness of breath related to cardiac disease and probably his body stature. His x-ray and findings are not consistent with coal workers' pneumoconiosis.

(DX 23).

(3) **A. David Russakoff, M.D.**, a board-certified pulmonologist, reviewed the records and issued a report dated December 29, 2003. After summarizing the material reviewed and

[10] As used herein, a board-certified pulmonologist is a physician who is board-certified in internal medicine and the subspecialty of pulmonary diseases.

clinical data, he responded to questions posed by the Employer. On the question of whether Claimant has coal workers' pneumoconiosis or any other dust-related disease of the lungs, he opined that he did not for the following reasons:

> . . . In my opinion, based on the medical data available to me to review, Mr. Crear does not have coal workers' pneumoconiosis or any other dust-related disease of the lungs. I base this opinion on the absence of any of the characteristic changes one would expect to see on the chest x-ray of rounded, regular opacities or conglomerate masses that would be necessary to explain the severe alterations in his pulmonary function tests. All of his findings and symptoms can be attributed to his obesity, heart disease, chronic sinus disease.

(DX 24). Dr. Russakoff went on to state his opinion that the Claimant was totally disabled from a pulmonary standpoint but he opined that the abnormal pulmonary function was due not to any primary condition of the lung but to other processes, such as morbid obesity, hypertensive cardiovascular disease, and post-operative effects of an abdominal gun shot wound (elevated diaphragm), and he attributed the symptoms/history of cough, phlegm, shortness of breath, and wheezing to those processes and possibly to early congestive heart failure *Id.* Dr. Russakoff also disagreed with Dr. Kahn's conclusion that the Claimant has COPD and stated that there was no evidence of such based upon the pulmonary function testing, which showed a "classic restriction and not obstruction." *Id.*

(4) **Ernest A. Claybon, M.D.,** a family practice practitioner and the Claimant's treating physician, issued a report dated October 7, 2004, in which he indicated that he had treated the Claimant for ten years and that the Claimant had been diagnosed with pneumoconiosis in 1998. (CX 1). He explained that Claimant has chronic obstructive pulmonary disease, chronic sinusitis, and lung disease, accompanied by a chronic cough, congestion, wheezing, rales and rhonchi in his lungs, and he stated that the Claimant had a severe breathing problem which predated his obesity, thereby ruling out obesity as the cause of his pulmonary problems. (CX 1). Finally, he stated that the Claimant was totally disabled and would be unable to perform any kind of manual labor or job. As a rationale, he stated the following:

> . . . . My diagnosis is based on my more than ten years of treating Mr. Crear, his employment history, his history of smoking and his medical history. The patient has no history of smoking. As a consequence, I am reasonably certain that his smoking is not the cause of his chronic obstructive pulmonary disease, chronic sinusitis and pneumoconiosis. He worked in underground mines for several years, and was exposed to coal dust on a daily basis. After working in underground mines for fourteen years, he started complaining of shortness of breath. Based on Mr. Crear's work history, medical history(attached)[11] and smoking history, I am reasonably certain that his chronic obstructive pulmonary disease, chronic sinusitis and pneumoconiosis were caused by exposure to coal dust while working in an underground mine.

[11] The attached records dated from 1996 to 1998. (CX 1).

(CX 1). Attached to that report were medical records from Dr. Claybon dating from 1996 to 1998 which included references to "cough, persistent" (in December 1996), "COPD" (in February 1997), "COPD/asthma/emphysema" (in April 1997), and "shortness of breath" (in July 1997), as well as multiple references to "sinusitis," but did not address the etiology of these conditions or findings. *Id.*

In addition to the above, **Dr. Jack Hassan** examined the Claimant for the Department of Labor on February 24, 1999 in connection with the previous claim (DX 1, DX 20). In his examination report, Dr. Hassan listed the following under cardiopulmonary diagnoses and bases:

1. No Evidence of Pneumoconiosis Hx [History], PE [Phys. Exam], [? - Illegible], CXR [Chest x-ray]
2. HCVD [Hypertensive Cardiovascular Disease] Hx, PE
3. Fullness of mediastinum – [Illegible] CXR
4. Asthmatic Bronchitis Hx

(DX 1, DX 20). Dr. Hussan found the disability due to the second condition to be severe and found it to make the majority contribution to the impairment; he indicated that the disability due to the third condition was to be determined and the fourth was "N/A" [not applicable]. *Id.*

Thus, of the four physicians expressing opinions in connection with the instant claim, two (including the treating physician) found the Claimant to suffer from "legal pneumoconiosis" and two did not. In addition, the physician who conducted the examination in connection with the earlier claim did not find "legal pneumoconiosis." None of the physicians found the Claimant to have x-ray evidence suggestive of pneumoconiosis and there is no support for a finding of clinical pneumoconiosis. As noted above, there is no x-ray evidence of pneumoconiosis, and there are no biopsies or CT scans of record. The crux of this case is therefore whether the new medical opinion evidence supports a finding of legal pneumoconiosis.

Factors to be considered when evaluating medical opinions include the reasoning employed by the physicians and the physicians' credentials. *See Millburn Colliery Co. v. Hicks***,** 138 F.3d 524, 536 (4th Cir. 1998). A doctor's opinion that is both reasoned and documented, and is supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *See Fields v. Island Creek Coal Co.,* 10 BLR 1-19, 1-22 (BRB 1987) (stating that a "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis, and that a "reasoned" opinion is one in which the underlying documentation is adequate to support the physician's conclusions). In addition, the new regulation appearing at §718.104(d) allows additional weight to be given to the opinion of a treating physician but requires certain factors, including the nature and duration of the relationship, the frequency of treatment, and the extent of treatment, to be considered.

First, I will consider the credentials of the physicians. Drs. Goldstein and Russakoff obviously possess the credentials to express an opinion on the Claimant's pulmonary condition as they are board certified in internal medicine and the subspecialty of pulmonary diseases, and both have impressive curricula vitae. Although the credentials of Drs. Khan and Hassan are not

of record, they appear on the list of physicians qualified to perform pulmonary examinations on behalf of the Department of Labor and may be presumed to be qualified to conduct pulmonary examinations. Dr. Claybon's credentials are of record, and I note that he is a qualified family practitioner as well as the Claimant's treating physician for ten years, treating him several times each year in the late 1990's, although the records do not reflect treatment in recent years. While Dr. Claybon has not treated the Claimant for pneumoconiosis per se, he has treated him for coughs, shortness of breath, "COPD/asthma/emphysema," and sinusitis that he now attributes to coal mine dust exposure. These factors allow his opinion to be given special consideration as treating physician. 20 C.F.R. §718.105(d). However, on the issue of the etiology of Claimant's condition, I find that the specialized training possessed by Drs. Goldstein and Russakoff provide them with an advantage in interpreting the pulmonary and respiratory testing involved here.

Turning to the reports themselves, I find that the report by Drs. Goldstein and Russakoff are the best reasoned in that they have addressed all of the clinical findings and their possible etiologies, and they have pointed to specific findings supporting their conclusions.

First, they have pointed to the pulmonary function test findings of a restrictive defect and have pointed out how that undermines the diagnosis of COPD by Drs. Khan and Claybon. Given their superior qualifications, I assign more weight to the consensus by Drs. Goldstein and Russakoff (that the defect is restrictive in nature) than to the contrary interpretation by Dr. Kahn, whose credentials are not of record. It is worth noting that Dr. Khan initially found a restrictive defect also, but he changed his findings without explanation. As Dr. Claybon has not explained the basis for his determination that the Claimant has obstruction, I cannot assign any weight to that determination.

Second, Drs. Goldstein and Russakoff pointed out that if coal dust were a factor in producing the significant pulmonary function findings, one would also expect to see some x-ray abnormalities. However, the x-rays have been uniformly interpreted as negative for pneumoconiosis. In so arguing, the thrust of their comments is that the magnitude of impairment is inconsistent with a lack of x-ray findings, not that x-ray findings are necessary for a diagnosis of legal pneumoconiosis. The significance of the lack of x-ray findings was not addressed by Drs. Claybon and Kahn.

Third, Drs. Goldstein and Russakoff have discussed other possible etiologies, but the analyses by Drs. Kahn and Claybon are cursory on that issue. In this regard, Dr. Khan's analysis depends upon the Claimant's exposure to coal mine dust and lack of cigarette smoking history, but he does not really address other possible etiologies, such as the Claimant's obesity and cardiovascular disease. Turning to Dr. Claybon, his records substantiate that the Claimant has been diagnosed with heart disease and hypertension. While he attributes the Claimant's heart enlargement to the lack of oxygen in the coal mines, Dr. Claybon's opinion does not adequately address the Claimant's other health problems. Dr. Claybon has discounted any contribution by the Claimant's weight based upon the inaccurate assumption that he only recently became obese. Claimant testified that his weight has fluctuated but was in the same range (280 pounds) in 1996, when he worked in the mines, and Dr. Claybon's own records so reflect. (CX 1).

On balance, I find that the medical opinion reports by Drs. Goldstein and Russakoff outweigh those of Drs. Claybon and Khan and the reports as a whole do not therefore support a finding of legal pneumoconiosis.

The only medical opinion evidence previously of record is Dr. Hassan's examination report from 1999. I give Dr. Hassan's report little weight as he has not had the advantage of reviewing evidence in the record since 1999. Moreover, his report does not support a finding of pneumoconiosis so it is of no assistance to the Claimant in establishing that he suffers from pneumoconiosis.

In view of the above, I find that the preponderance of the medical opinion evidence does not support a finding of pneumoconiosis and Claimant has not established pneumoconiosis under section 718.202(a)(4).

Other Evidence. Apart from the medical records discussed above, there is no other medical evidence on the issue of pneumoconiosis. There are no CT scans, and the medical records submitted from Dr. Claybon do not list pneumoconiosis as a diagnosis or list the etiology for the COPD, sinusitis, emphysema, and asthma noted. Thus, the Claimant cannot establish pneumoconiosis based upon this evidence.

Section 718.202 as a Whole. Looking at the newly submitted evidence under section 718.202 as a whole, I find that the new evidence on the issue of whether the Claimant has pneumoconiosis as defined in the Act and the regulations fails to preponderate in favor of such a finding. Further, the evidence previously of record does not support a finding of pneumoconiosis. When all the evidence of record, positive and negative, is considered, I find that the Claimant has failed to establish the existence of pneumoconiosis by a preponderance of the evidence. This claim must therefore fail.

Conclusion

In view of the above, I find that the claim must be denied based upon Claimant's failure to establish pneumoconiosis, a necessary condition of entitlement, based upon all of the evidence of record. It is therefore unnecessary to consider any other issues.

ORDER

IT IS HEREBY ORDERED that the claim of Harrison Crear for black lung benefits under the Act be, and hereby is **DENIED.**

A

PAMELA LAKES WOOD
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on the Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.